Medical Information Form

To be completed by a Parent or Guardian if traveler is under 18

Good Shepherd Roman Catholic Church

867 Gray's Woods Blvd.. State College, PA 16803

Telephone : (814) 238-2110

(Please print neatly)

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Social Security # (may be needed for medical records) _____ Home Phone # ( )_____

Complete Parental information if traveler is under 18:

Mother's name _____ Work. Phone # ( ) _____

Father's name _____ Work Phone # ( )_____

Second parent or guardian's name _____ Work Phone #( )_____

(If applicable):
Address _____

City _____ State _____ Zip _____ Country _____

Home Phone# ( )_____ Work Phone# ( )_____

** Alternate Emergency Contact Person _____ _____ Relationship _____
Address. _____ _____ _____

Phone # (_____) _____ or Cell Phone # _____

1. Please indicate your hospitalization information for emergency use.
   Carrier _____ Policy # _____
   Group Policy # _____ _____
   Address of Carrier _____ _____
   Parent # _____ _____

2. Name of family physician _____ Phone # ( )_____
3. Name of family dentist _____ Phone # ( )_____

Has there been any history of the following? Please explain checked item on a separate sheet of paper.

- o Allergies
- o Asthma
- o Headaches
- o Cramps
- o Eating Disorders
- o Foot Problems
- o Epilepsy
- o Injuries of any kind
- o Heart Problems
- o Hepatitis
- o Mononucleosis
- o High Blood Pressure
- o Phobias (claustrophobia, etc.)
- o Pneumonia
- o Back Problems
- o Chronic Pain
- o Diabetes
- o Dizziness
- o Infectious Disease
- o Fainting
- o Recurrent Dental Problems
- o Lymes Disease
- o Mental Illness
- o Gastrointestinal Problems
- o Blood Clots

6. Please list any medications, vitamins, etc. that you take on a regular basis. Will they be brought on the trip?
7. Please list all immunizations and dates on the back - include date of last Tetanus shot.
8. Are there any dietary considerations we should know about? Explain on back or a separate sheet (if needed)

Parent/Guardian PERMISSION TO TREAT STATEMENT: Any sickness or injury arising during the trip can be examined and verified by a licensed physician of the mission leader's choosing. Permission is granted to the mission leaders in a medical emergency to hospitalize, treat, order injections, anesthesia or surgery for my child. It is also agreed and understood that Good Shepherd Church's mission leaders will make every reasonable attempt to immediately contact this team member's parents or guardians.

Date _____ Parent/Guardian Signature _____